# ATTACHMENT 7
# Sample Prior Authorization Request Form (PA/RF) for vision services

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

**STATE OF WISCONSIN**
HFS 106.03(4), Wis. Admin. Code

**WISCONSIN MEDICAID**
**PRIOR AUTHORIZATION REQUEST FORM (PA/RF)**

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

| **FOR MEDICAID USE —** ICN | AT | Prior Authorization Number |
|---|---|---|
| | | 1234567 |

**SECTION I — PROVIDER INFORMATION**

| 1. Name and Address — Billing Provider (Street, City, State, Zip Code) | 2. Telephone Number — Billing Provider | 3. Processing Type |
|---|---|---|
| **I.M. Provider, O.D.**<br>**1 W. Williams**<br>**Anytown, WI 55555** | **(XXX) XXX-XXXX** | **122** |
| | 4. Billing Provider's Medicaid Provider Number<br>**87654321** | |

**SECTION II — RECIPIENT INFORMATION**

| 5. Recipient Medicaid ID Number | 6. Date of Birth — Recipient (MM/DD/YY) | 7. Address — Recipient (Street, City, State, Zip Code) |
|---|---|---|
| **1234567890** | **MM/DD/YY** | **609 Willow**<br>**Anytown, WI 55555** |
| 8. Name — Recipient (Last, First, Middle Initial) | 9. Sex — Recipient | |
| **Recipient, Im A.** | ❑M ☒ F | |

**SECTION III — DIAGNOSIS / TREATMENT INFORMATION**

| 10. Diagnosis — Primary Code and Description | 11. Start Date — SOI | 12. First Date of Treatment — SOI |
|---|---|---|
| **366.9 Unspecified Cataract** | | |
| 13. Diagnosis — Secondary Code and Description | 14. Requested Start Date | |
| **368.13 Photophobia** | | |

| 15. Performing Provider Number | 16. Procedure Code | 17. Modifiers 1 | 2 | 3 | 4 | 18. POS | 19. Description of Service | 20. QR | 21. Charge |
|---|---|---|---|---|---|---|---|---|---|
| | **V2744** | **SC** | | | | **11** | **Tint, photochromatic, per lens** | **2** | **XX.XX** |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

| 22. **Total Charges** | **XX.XX** |
|---|---|

| 23. **SIGNATURE** — Requesting Provider | 24. Date Signed |
|---|---|
| I.M. Provider | **MM/DD/YY** |

**FOR MEDICAID USE**

Procedure(s) Authorized: Quantity Authorized:

❑ Approved

Grant Date _____ Expiration Date _____

❑ Modified — Reason:

❑ Denied — Reason:

❑ Returned — Reason:

_____ _____
**SIGNATURE** — Consultant / Analyst Date Signed